Need for a full-service hospital on Reservation 13

The District and Howard University have engaged in numerous studies and analyses to determine the extent to which District residents would be well-served by a hospital located on the site of U.S. Reservation 13. The results of this work are clear. There is an authentic need for a hospital of roughly 250 beds that provides a comprehensive array of health services, serving primarily residents of Wards 5, 6 and 7.

The National Capital Medical Center (NCMC) is needed for four major reasons: 1) to create a better geographic distribution of hospital services, 2) to increase overall capacity, especially for emergency care, 3) to serve as a hub for the community health network in Northeast and Southeast, and 4) to disperse the current clustering of District hospitals, which could be problematic in the event of a major disaster.

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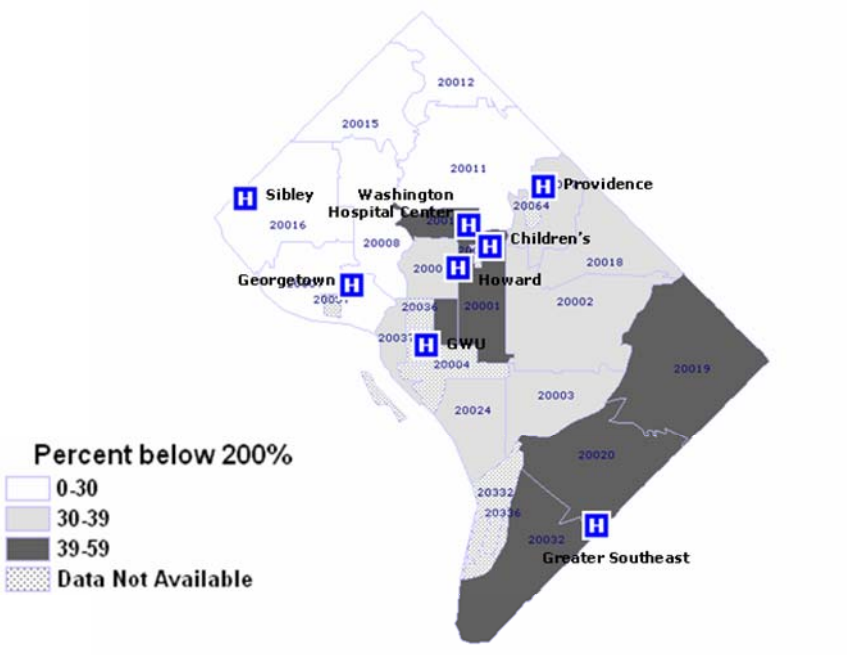
Need for better geographic distribution of hospitals

When the Council first enacted the "National Capital Medical Center Negotiation Emergency Act" in November 2003, the legislation noted that "the District's existing healthcare infrastructure is inadequate in part because of the uneven distribution of hospitals throughout the city." Since then, much research has been completed to confirm this statement.

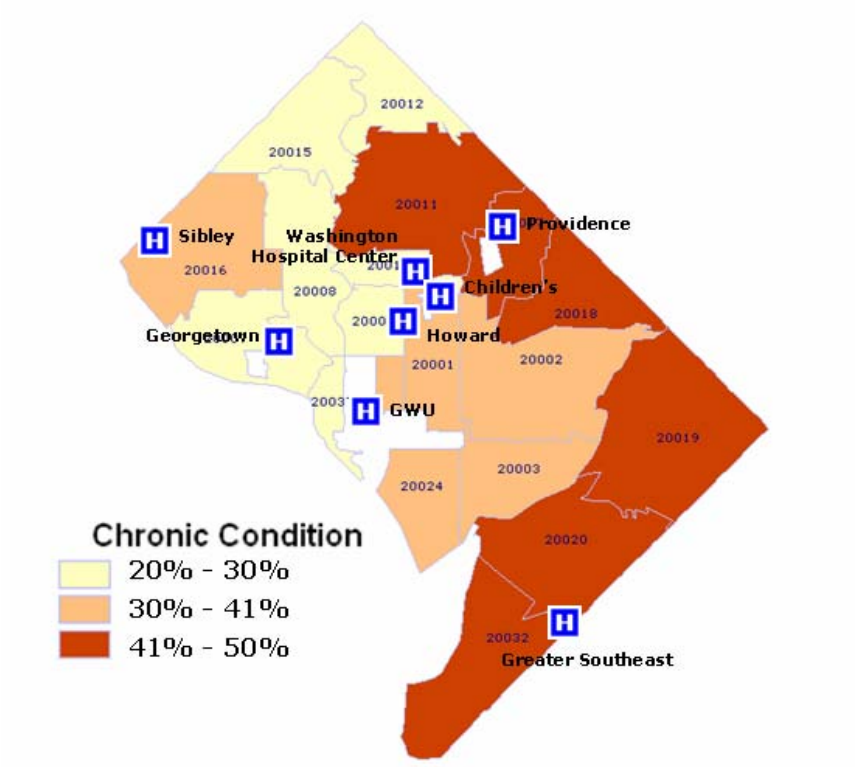
The District's hospital facilities are predominately concentrated in the central and western areas of the city, with just one hospital east of the Anacostia River in Ward 8. However, much of the need for healthcare services in the District is in areas that are not proximate to a hospital. Many of the most densely populated neighborhoods are located in Northeast and Southeast. Moreover, these densely populated neighborhoods without easy access to a hospital are highly concentrated with the District populations who are most in need of medical services, such as residents below 200 percent of the federal poverty level, residents covered by Medicaid and the DC Healthcare Alliance, women of childbearing age, and children. In addition, according to a recent study commissioned by the DC Primary Care Association, the RAND Corporation found that many of the neighborhoods with the highest concentrations of chronic illness do not have immediate access to a hospital. In these neighborhoods, as much as 50% of the population has Diabetes, Asthma and/or hypertension.

Location of Low-income Residents and District Hospitals



Source: 2000 U.S. Census Bureau

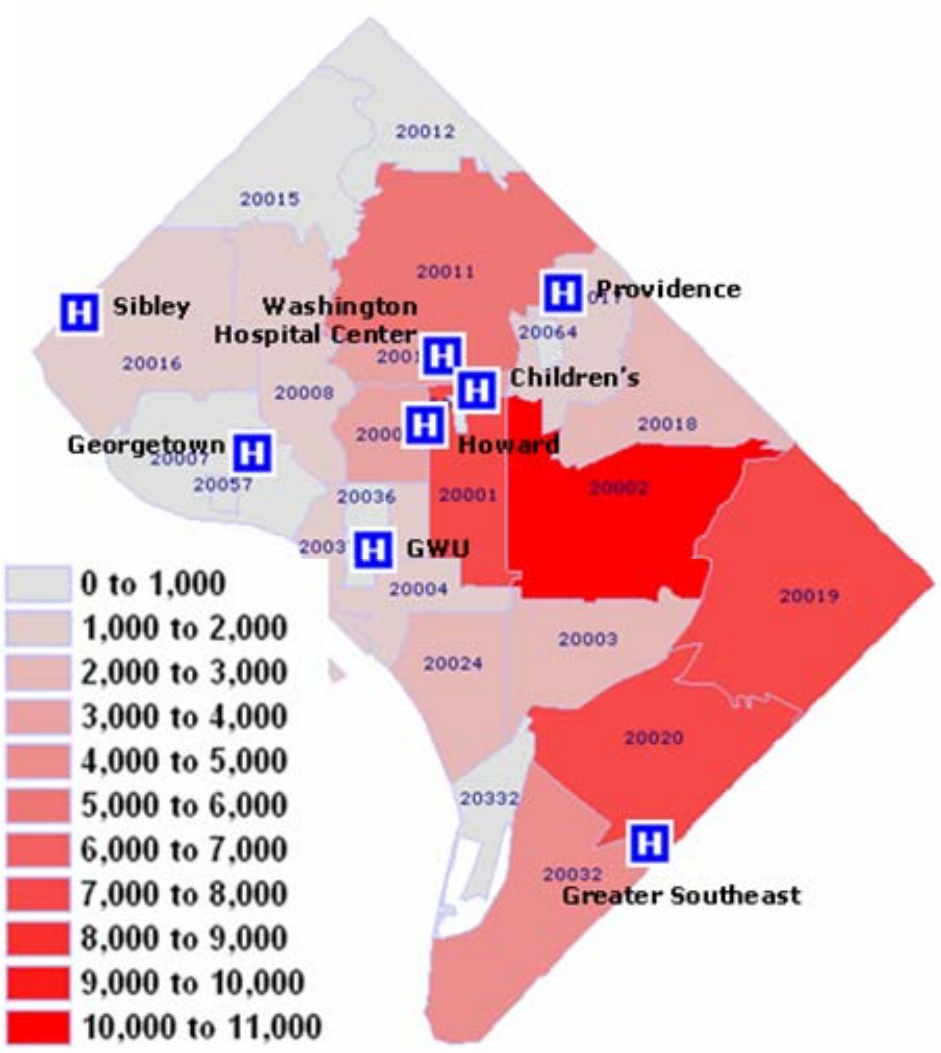
Location of Chronic Disease Burden and District Hospitals



Source: RAND Corporation Analysis sponsored by DC Primary Care Association

The mismatch between the need and the location of services is particularly pronounced for emergency and trauma services. In 2004, 27% of all District EMS calls came from areas east of the Anacostia River, where there are no trauma services and only one emergency room at Greater Southeast Community Hospital, which is on the Southeast border with Prince George's County. Another 22% of EMS calls came from areas just west of the Anacostia River, near Reservation 13. Major traffic congestion between these locations of need and the District's existing hospitals can compromise the health of patients who must be transported long distances to receive care in life-threatening circumstances.

Origin of EMS Ambulances and Location of District Hospitals

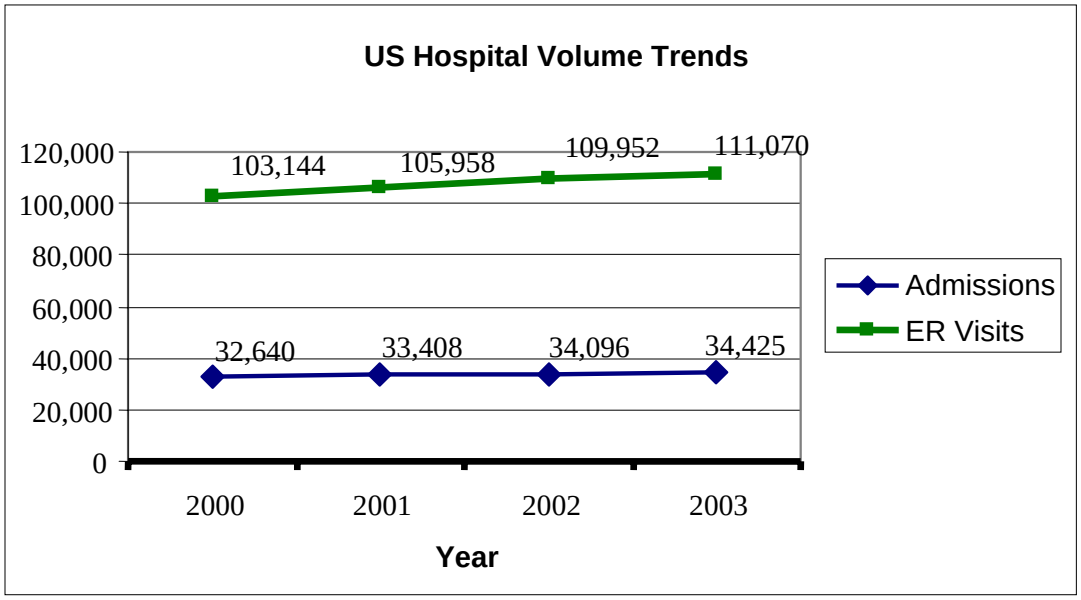


Source: District Fire & EMS

Thus, the areas of the city with the highest concentrations of people needing healthcare services—especially the poor and the chronically ill—are the least accessible to key health services. Residents of these underserved neighborhoods must travel across the city for emergency and trauma care, inpatient care, surgical procedures, and diagnostic tests. And because specialty physicians tend to practice in close proximity to hospitals, they must also frequently travel to see a doctor.

Need for additional capacity

In addition to a need for redistribution of hospital services, the District is also likely to have a need to expand total hospital capacity in the coming years. Statistics from around the country show that after more than a decade of hospital consolidations and declines in the number of beds, the need for hospital services is now increasing. In the 1990s, the number of beds in the U.S. sharply declined due to dramatically reduced lengths of stay and a major shift from inpatient to outpatient procedures. These changes were largely due to advances in minimally invasive technologies, a new Medicare payment methodology, and the pressures of managed care. In the 2000s, new trends such as the aging of the population, different medical technology advances, and the relaxation of managed care practices are gradually increasing the need for hospital services nationwide.



The District of Columbia is beginning to see similar trends, and may soon or already need additional ER (Emergency Room) capacity and operating hospital beds. One way to evaluate whether the District's current ER capacity is sufficient to meet the demand is to examine the number of hours of ER closure and diversion

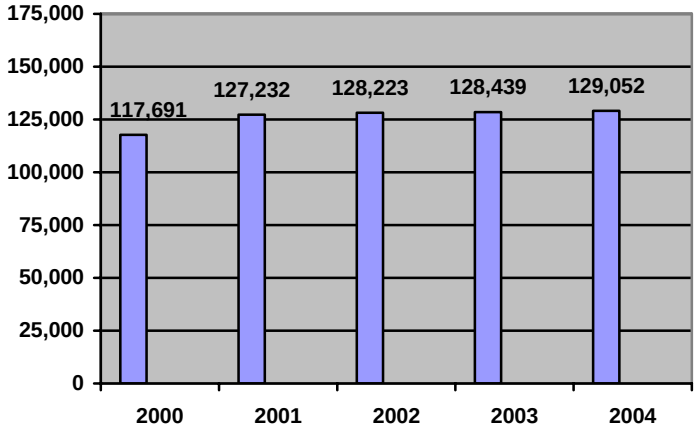
at District hospitals. Hospitals frequently ask District EMS to reroute ambulances to other facilities when their ERs are at capacity or when the number of open beds in the adjoining hospital is not sufficient to accommodate more very sick patients. The number of hours of diversion and closure more than doubled over the past five years, from 3599 hours in 2000 to 7515 hours in 2004. This suggests that there is indeed a need for additional ER capacity.

The American College of Emergency Physicians came to the same conclusion in its recent report on Access to Emergency Care in the District of Columbia. The report stated:

"[The District] risks losing its excellent standing in Access to Emergency Care because emergency departments are regularly reaching their capacity, and patients are frequently and increasingly diverted to other facilities. At the same time, four hospitals in the District have closes in the past 10 years. If these trends continue, patients will suffer, and the District's Access to Emergency Care grade will fall. District of Columbia officials need to act, perhaps by reopening or building new emergency care facilities."

In addition, it appears that after years of decline District hospitalizations may be on the rise. The number of staffed acute care beds in the District declined by 476 in recent years with the closures of DC General and the Columbia Hospital for Women and the conversion of Hadley Memorial to a long-term care facility. In addition, all remaining District hospitals currently operate far fewer beds than their licenses allow. During the fourth quarter of 2004, the total number of licensed DC acute care beds was 3914, with only 2651 beds in operation.[1] But the number of total acute care admissions is now slowly increasing in the District.

Number of District Acute Care Admissions, 2000-2004



[1] District of Columbia Hospital Association

Source: DC Hospital Association

As a result, after years of decline, the need for hospital beds is likely to grow in the near future, mirroring national trends. Our analysis suggests that if the District population and the rate of hospitalization were to remain stable, by 2008 the District would require another 349 operating beds. If the District population were to grow by 23,500 (half the growth projected by the Office of Planning) and the rate of hospitalization declined somewhat, by 2008 the District would require an additional 218 operating beds.[2]

Some might argue that existing hospitals could fill the increasing need for beds and emergency care by opening inpatient wards that they have closed over the years and expanding the size of their emergency rooms. However, given the stark mismatch between the location of existing services and the areas of predominant need, a strong case can be made that any new operating beds should be located in the areas of greatest need, on the Eastern side of the District. Reservation 13 is an ideal location, given its proximity to major transportation thoroughfares and historical healthcare context.

Need for a community health network hub and key public health services

The east side of the District is in need of a major medical facility to anchor the developing community health network. There are currently some primary care providers located in these underserved areas--community health centers and private physician practices that focus primarily on the publicly insured and uninsured populations. This network is poised to expand and improve as the Medical Homes initiative progresses. However, these community providers are often stymied in their goal of providing adequate care for their patients because of a lack of available specialty physicians to provide consultations and no readily available referral point for major diagnostic testing. Frequently, these providers are forced to tell their patients to travel across the city to a hospital emergency room to seek these services, since there are no local facilities to which they can proactively refer patients. As a result, many patients do not receive necessary care, or they receive care inefficiently, in a hospital ER.

A new medical center on the Reservation 13 campus could serve as a referral point for community providers seeking specialty and diagnostic services for their patients. Through formal referral agreements and information technology connecting hospital providers, a new medical center can provide the missing link in the current continuum of care.

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[2] Stroudwater Associates

Need to disperse the cluster of hospitals

In addition to correcting this mismatch between the location of existing facilities and the everyday demand for services, Washington, DC must also consider the implications of hospital location in the event of a major disaster or breach of homeland security. In such an unfortunate situation, it will be crucial for District health delivery services to be spread out across the city, so that if hospitals in one area are affected, others can continue to provide life-saving services.

However, we currently have a major cluster of hospitals in a vulnerable location in the center of the city. Washington Hospital Center, Children's National Medical Center, Howard University Hospital, the Veteran's Administration Hospital, and Providence Hospital are all in very close proximity to one another. Moreover, the three Level One Trauma Centers in the District, Howard University Hospital, Washington Hospital Center and Children's National Medical Center, are all within a mile of each other. If all of those hospitals became incapacitated at the same time, or if residents from the East side of the District could not reach them, lives would be lost. The District's emergency and trauma capacity must be better distributed across the city, both for better access on a daily basis, but perhaps more importantly, for access in a crisis situation.